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Letters to the Editor

Püchel K, Bachmann D. Proving possession of drugs in so-called body-stuffers. *J Forensic Legal Med* 2007;**14**:96–8

The problem of drug-related adverse health outcomes and near miss incidents is a substantial one in the police context[1,2] and undeniably presents an added diagnostic and management dilemma for the attending forensic physician. Because of the often unplanned and impromptu nature of ingestion, body-stuffers may ingest drugs that are poorly wrapped and hence run the risk of drugs entering the body system.

Püschel and Bachmann discuss the use and safety of administering ipecacuanha syrup (ipecac syrup) in order to retrieve drugs from body-stuffers through pharmacologically inducing vomiting. However, the options available for law enforcement agencies to retrieve evidence and withdraw it from further circulation need to be weighed up carefully against possible further harm to the detainee.

The concept of emptying the stomach after the ingestion of a poison or drug overdose has been intuitive throughout history, the human finger most probably being the first method employed to induce vomiting. Later minerals and plants were discovered to be effective for inducing vomiting (e.g. salt water). The use of ipecac syrup might have an acceptable benefit-to-risk ratio in rare situations in which (a) there is no contraindication to the use of ipecac syrup; (b) there is substantial risk of serious toxicity to the victim; and (c) there is no alternative therapy available or effective to decrease gastrointestinal absorption (e.g., activated charcoal). However, the use of ipecac syrup is not without its own limitations; the effectiveness in removing ingested materials declines rapidly with time and is substantially reduced after 30–90 min.[3] Adverse effects of ipecac syrup include hyperemesis, diarrhoea, orthostatic hypotension, lethargy, irritability/hyperactivity, fever, diaphoresis, and potential risk of pulmonary aspiration of gastric contents. Furthermore, risky attempts to open the jaw by force in order to administer ipecac syrup carries a significant infection risk to attending staff if bitten[4] and exposes the body-stuffer to potential drug exposure through tearing of the drug wrapper.[5] The authors conclude that other less-invasive methods (e.g. a period of observation), would infringe on basic human rights and are not generally recommended. However, it is puzzling to read that although a detainee cannot be forced to drink the emetic, a nasogastric tube can be inserted against the detainee's will (so as to administer the emetic). It is hard to conceive how the forceful insertion of any nasogastric instrumentation in these circumstances cannot also be considered an infringement of basic human rights.

However, the more important issue here is whether forensic physicians should be party to intervention where the primary aim for emesis is for legal (evidential) purposes (and not medical). Indeed, the authors correctly state that bodystuffing cannot readily be established unless there is a witnessed act of swallowing by the police. However, the real danger exists that emesis can be induced when false claims of drug ingestion are made in the hope of avoiding detention in a police cell and facilitating escape.[6]

The safest approach would be to speedily convey body-stuffers to hospital at the earliest opportunity (where resuscitation facilities are available) without attending the custody suite. This is the recommended practice in the United Kingdom. The problem remains that many detainees swallow their inventory surreptitiously and before symptoms have developed. However, a blanket policy of hospital observation for all asymptomatic body-stuffers would also not be feasible. Norfolk has provided a rational approach to the asymptomatic bodystuffer in relation to time after ingestion.[6] These guidelines seem reasonable on proviso that the time of supposed ingestion is recorded and that the forensic physician is able to make a reasonable judgement as to the type and integrity of the package material.

There remain unknown variables which the forensic physician is not in a position to determine accurately (and with assurance) such as the quantity, nature of drug(s) taken, possibility of delayed drug absorption and interactions, time of most recent ingestion and prior drug intake. However, to enforce medical intervention against the detainee's will, primarily for confiscating contraband-, cannot be deemed acceptable practice. It is imperative that police officers and forensic physicians adopt a safety first approach when dealing with a potential body-stuffer. The impromptu ingestion

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of illicit drugs may be unavoidable at times however it is not unpredictable. Meticulous risk assessment with use of an appropriate observation period by a vigilant forensic physician is essential to safeguard the wellbeing of the detained body-stuffer and avert deaths in custody.

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Racist aggression towards FMEs

Sir,

Recent comments from Judge Paul Darlow in Exeter Crown Court (Exeter, UK) create a troubling impression. As reported in The Times, the court heard that a 36-year-old detainee who had asked to see a doctor, told the forensic physician (FP) "I want an English doctor, not a f***ing Paki".[1] The FP described how the detainee had "lunged" at him. The judge told the man "Next time call him a fat bastard and do not say anything about his colour." He went on to explain that given the situation, comments made by a "drunk" towards the FP could not be deemed to be "seriously upsetting abuse". Doctors from a variety of ethnic backgrounds working in the UK will consider Judge Darlow's attitude to be quite peculiar and not in keeping with current opinion. This is particularly the case, considering that he made his remarks in the same week that Jade Goody almost created an international incident after allegedly racist remarks on television Channel 4's Celebrity Big Brother television programme! Equally surprising, perhaps is the way that the judge implies that it is acceptable to direct verbal aggression of a non-racist nature towards doctors at work. There are limited data in the clinical forensic setting although studies have been undertaken over a decade ago, but the full extent of aggression being directed towards healthcare workers in various settings appears to be gradually being realised.[2–5] I believe that medical and legal professionals at every level need to take this problem seriously in order that it may be tackled.

Declaration of interest

I work as a forensic physician in a neighbouring county.

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